Fact Sheet

NATIONAL COUNCIL OF SENIOR CITIZENS

Medicare

Background

Medicare is a Federal health insurance program for people aged 65 or older, and persons under 65 who are disabled or who suffer from end-stage renal disease (ESRD). The program covers approximately 37 million Americans. Medicare consists of two parts:

- Part A—Hospital Insurance (HI) pays for in-patient hospital care, certain in-patient care furnished in skilled nursing and rehabilitation facilities, home health care and hospice care. It is financed through a 1.45 percent payroll tax (on both the employer and employee). To qualify, someone must have paid in for 40 quarters and be 65 or older. Disabled persons qualify after qualifying for Social Security disability payments for two years. People suffering from kidney failure (ESRD) qualify immediately. Others can buy into Part A upon reaching 65. There is a deductible equal to the cost of one day's stay in a hospital for practically every hospitalization.

- Part B—Supplementary Medical Insurance (SMI) pays for medically necessary physicians' services, out-patient hospital services, treatment for ESRD, laboratory services, durable medical equipment and certain other medical services and supplies. Part B is financed through premiums and from general tax revenues. The premiums are currently set to cover 25 percent of Part B program costs. There is a hundred dollar deductible and a 20 percent co-payment for all services received under Part B. Part B is voluntary, but 98 percent of those eligible have entered the program.

Issues

Provider Reimbursements

The argument is that "Medicare" is going "broke" and the "rate of growth" needs to be slowed in order to maintain the solvency of the program. The 1995 Republican plan was to take $270 billion out of Medicare over a seven-year period. This money was not going to be used to improve the program and only a portion would be used to extend the life of the Part A trust fund. Instead, most of it was to be used for other purposes—primarily to finance tax cuts. Now the Republicans are saying they need to take "only" $168 billion from Medicare—still far more than is needed to correct the upcoming Part A shortfall.

Medicare currently reimburses providers about 68 cents for every private pay dollar for the same services. Lowering reimbursements further threatens to make the program economically unattractive to providers. As providers begin to turn away Medicare patients, the beneficiaries will have no choice but to join managed care programs. This is how millions of older Americans will be forced into managed care—limiting their choice of physician and other providers of health services as the "price" for managed care efficiencies.

over, please...

NATIONAL COUNCIL OF SENIOR CITIZENS

1331 F STREET, N.W. • WASHINGTON, D.C. 20004 • (202) 347-8800

In many ways, the proposed structural changes are more harmful to the viability of the Medicare program than the dollars taken out. We can always put money back in, but restoring balance billing limits and helping people to get out of unresponsive HMOs would take a huge effort. Let's not lose what we have fought for all these years.

Managed Care

Managed care should remain a viable alternative for Medicare beneficiaries as it is in the current program. However, managed care should remain a true option, not something someone is forced to join because they either cannot afford to stay in the traditional program or because providers will no longer take them in the fee-for-service program. Beneficiaries must have quality, access and marketing protections as well and must have the right to disenroll from managed care and to return to the regular Medicare program within 30 to 60 days.

Medical Savings Accounts

The argument is made that by offering Medicare beneficiaries a Medical Savings Account (MSA) option they will spend their health care dollar more wisely because they will be spending their own money. To a certain degree, this is true. The danger with MSAs is twofold. Only beneficiaries with low expected costs would find an MSA attractive. Beneficiaries with high costs would not, since Medigap insurance policies plus traditional Medicare would provide a cheaper alternative. Also, this self-selection process will be costly as well as risky. The nature of social insurance is that healthy people pay in and the risk is spread. With MSAs, healthy people withdraw themselves from the social insurance program and actually take money out of the system instead of putting it in. Estimates are that it would cost Medicare roughly $2,400 extra for every beneficiary who chose the MSA.

Health Care Costs

Some people argue that only by getting Medicare costs "under control" will we be able to control the Federal budget. While this is true on the surface, Medicare growth is only part of the overall health care picture. Medicare costs are under control. Physicians are paid under a fee schedule. Hospitals are paid through DRGs. When population growth rates and benefit changes were held constant, it was found that private sector health costs grew at seven percent last year, while Medicare grew at 7.1 percent, in spite of the fact that Medicare treats an older, sicker population. The only sure way to control Medicare costs is to control the overall rate of growth in all health care sectors, including private insurance. Giving Medicare away to the private insurance industry will not solve the problem. Medicare spends only two percent of its budget on administrative costs, while the largest group insurance companies spend between five and 15 percent. It is hard to imagine how we can save money by moving to a system that is less efficient than the one we already have in place.

Physician Overcharges

Currently, doctors are permitted to charge Medicare beneficiaries no more than 15 percent above Medicare-approved rates. The 1997 GOP budget weakens this protection by allowing doctors who serve Medicare beneficiaries in private plans to charge them unlimited fees. As a result, beneficiaries who leave traditional Medicare for MSAs or other private insurance plans would lose an extremely popular benefit that was hard-won by grassroots senior action.

Hard Spending Cap

The GOP budget would impose a "hard cap" on Medicare spending that would hold the program to a specific rate of growth. If costs increased faster than projected, Medicare funding would not be able to cover them and the resulting cuts would be far deeper that the GOP's estimate of $168 billion.

Part B Premium Increases

In last year's budget bill passed by the House, Part B premiums would have gone up to $104.30 a month by the year 2002, an increase of $61.80 over the current premium of $42.50. Here's why: The House GOP bill would have permanently continued a soon-to-expire law that had temporarily raised the beneficiary's share of Part B costs from 25 percent to 30 percent. Instead, the law died as scheduled in January and the beneficiary portion of Part B reverted to the traditional 25 percent. (NCSC questioned why House GOP leaders wanted to increase Part B payments when they claimed their aim was to "save" the Part A Trust Fund.)

Quality of Care

Rather than penalizing beneficiaries directly, as with Part B premium increases, the GOP budget shifts cuts to providers, which indirectly penalizes seniors and other health care consumers. Cuts to hospitals, for example, will result in cost-shifting to patients and insurers, will threaten quality of care (caused by reduced staff and services) and will threaten the viability of many rural and inner-city hospitals.

For more information, contact: Jon Lawniczak, Senior Health Policy Analyst,
Department of Public Affairs and Legislation, National Council of Senior Citizens,
1331 F Street, N.W., Washington, D.C. 20004; (202) 624-9535 or (202) 624-9539.

Fact Sheet

NATIONAL COUNCIL OF SENIOR CITIZENS

What Are The Best-Kept Secrets About The Medicare and Medicaid Programs?

- **They work.**

Medicare and Medicaid provide quality health care to about 70 million Americans. The majority of these people would not be able to get health insurance through any other source. Providing insurance to this population actually saves health care dollars. Without it, these people will wait to receive care until a disease reaches a critical stage, making the illness harder and more expensive to treat.

- **Medicare is more efficient than the private sector.**

Administrative costs for the Medicare program are about two cents for every dollar we put into the program. Private large-group insurance averages between seven and 12 cents for every dollar. Small groups average between 25 and 32 cents for every premium dollar taken in. Medicare delivers more health care per dollar than the private market.

- **Medicaid is more than just a poor person's program.**

Medicaid is the largest payer of long-term care in the nation. Not many families can afford nursing home costs averaging approximately $40,000 a year. Without Medicaid, many families would be forced into bankruptcy to pay for an ailing parent's care.

- **Costs are under control.**

Medicare already has strong cost containment in place. Private insurers use the techniques developed by Medicare to keep their own costs down. When corrected for population growth and benefit changes, Medicare is growing at the same rate as private health insurance. Medicaid costs are being brought under control with states being given greater flexibility to run their programs.

Over, please...

NATIONAL COUNCIL OF SENIOR CITIZENS
1331 F STREET, N.W. • WASHINGTON, D.C. 20004 • (202) 347-8800

- **Medicare does not cover all health care needs.**

The Medicare program includes cost sharing to make certain people visit their doctors only when necessary. Patients must pay at least 20 percent of every bill. Medicare does not provide any long-term care services. Medicare does not provide prescription drug coverage. These are the two most costly items for senior citizens. People are forced to spend thousands of dollars a year on Medigap insurance policies in order to receive the kind of health insurance coverage they need.

- **Medicare is earned.**

People earn Medicare or buy into it. No one gets Medicare for free. There are three ways to qualify for Part A of Medicare: 1) You must be at least 65 years old and have paid into the system, while working, for at least 10 years. [Currently people pay 1.45 percent of wages into the Health Insurance Trust Fund. The employer matches this amount.] 2) After contributing to Medicare, you become permanently disabled. Medicare will then provide coverage only after you have been disabled for two years. 3) You develop End-Stage Renal Disease (kidney failure).

- **These programs respond to the needs of the populations they serve.**

Most people think government programs are unable to respond to changes in the programs they oversee. Medicare and Medicaid, however, are constantly changing to fit the needs of the beneficiaries. New benefits are being added over time. Comprehensive appeals processes are in place for people who feel they have been unjustly denied benefits. Finally, Medicare and Medicaid are held accountable for their actions by the Congress, which, ultimately, is accountable to the American people.

For more information, contact: Jon Lawniczak, Senior Health Policy Analyst, Department of Public Affairs and Legislation, National Council of Senior Citizens, 1331 F Street, N.W., Washington, D.C. 20004; (202) 624-9535 or (202) 624-9539.

Fact Sheet

NATIONAL COUNCIL OF SENIOR CITIZENS

Things to Oppose In Medicaid "Reform"

The following items have been discussed as a part of Medicaid "reform." If any of these are sections of any bill moving through Congress, the NCSC will oppose that bill.

1. Block granting Medicaid.

Block granting Medicaid means ending national healthcare standards and rules and giving it to the states to administer. The states would have the power to determine who should receive services and what kind of services they will receive. The NCSC believes that eligibility and services should be uniform and available in all states, that quality standards should be enforced at the federal level, and that since federal tax dollars finance the bulk of the programs, the federal government should manage the program in cooperation with the states.

2. Elimination of guaranteed access to services.

Many so-called reform efforts save money by eliminating the entitlement to services for particular categories of beneficiaries. For example, the National Governors' Association (NGA) would allow the states to define eligibility for specific services. The Breaux-Chafee, "moderate" approach in the Senate ties Medicaid eligibility to AFDC, cutting millions of people out of the Medicaid program. The NCSC believes that the same population groups currently receiving Medicaid benefits should continue to do so.

3. Cutting costs by cutting benefits.

Benefit cuts mean that people have to do without some services. Since Medicaid insures only the poorest of the poor, these people will not be able to afford to buy supplemental insurance to cover health services which are cut or reduced. The local public hospital emergency rooms will be crowded with citizens squeezed out of the Medicaid program. The NCSC believes benefits should be comprehensive in nature and should take care of all health-related needs.

4. Repeal of the Boren Amendment.

The Boren Amendment requires states to pay a fair Medicaid rate to nursing homes. Receiving a sufficient reimbursement means a nursing home can afford to hire and train the staff it needs and provide needed and humane services. This amendment is often the only thing that stands between a nursing home patient and staff cutbacks and poor services. The NCSC opposes repeal of the Boren Amendment.

over, please...

NATIONAL COUNCIL OF SENIOR CITIZENS
1331 F STREET, N.W. • WASHINGTON, D.C. 20004 • (202) 347-8800

5. Repeal of Spousal Impoverishment and Adult Child Protections.

Many of the politicians and conservatives working to cripple Medicaid believe they need to work with a "clean slate." To do this they would repeal Title XIX of the Social Security Act which authorizes Medicaid. In doing this, they would repeal all the protections consumers have fought for inclusion in the program for years. Included in this would be the elimination of Spousal Impoverishment protections designed to keep a spouse from having to pauperize him/herself when their spouse has to enter a nursing home. Also eliminated would be the provision saying an adult child does not have to use their own assets to pay for a nursing home stay for a parent before Medicaid kicks in.

6. Limiting Private Rights of Action.

Many proposals eliminate the ability of Medicaid patients to seek relief through the federal court system. The federal courts have helped standardize the Medicaid system and have imposed requirements on states that had declined to live up to their legal obligations. Curtailing access to the federal courts would stop people from getting the services they need when the state has illegally denied valid claims.

7. Repeal of Federal Nursing Home Standards.

Clearly, the standards and rules developed over the past fifteen years for nursing homes and their residents should not be thrown out. These standards protect people from the worst excesses of the industry and must remain in force. One way of eliminating the federal standards is to leave enforcement up to the states. Many states do not like the standards and would not enforce them as a way of cutting back on outlays of state dollars at the expense of nursing home residents. Often times the nursing home industry has closer ties to state legislators than they do at the federal level. This means that they will be able to convince these local legislators to reduce enforcement staff in order to keep them out of their homes. NCSC believes all nursing home standards should be enforced by the federal government while holding state governments accountable for the quality of day-to-day long-term care services.

For more information, contact: Jon Lawniczak, Senior Health Policy Analyst, Department of Public Affairs and Legislation, National Council of Senior Citizens, 1331 F Street, N.W., Washington, D.C. 20004; (202) 624-9535 or (202) 624-9539.